Breathing Center of Houston

Fax To: 713-660-0931

☐ **BELLAIRE**
6108 S Rice Ave Ste 100
Houston, TX 77081
Main: 713-660-0663

☐ **KATY FWY**
1127 Eldridge PKWY ste 800
Houston, TX 77077
Main: 346-410-5239

☐ **SUGARLAND**
2655 Cordes Drive Ste 110
Sugarland TX, 77479
Main: 281-870-4913

☐ **THE WOODLANDS**
17937 I-45 S ste 143
Shenandoah, TX 77385
Main: 936-273-0015

☐ **CLEAR LAKE**
1416 FM 528 ste A
Webster, TX 77598
Main: 281-672-7050

CYPRESS
COMING SOON!

Patient: _____
(Please fill in or attach patient demographics):
DOB: _____
Phone: _____
Insurance: _____
Subscriber ID: _____

Physician: _____
Phone: _____
Fax: _____
Referring Contact: _____

X	Evaluate and Treat Dysfunction Secondary To:				
☐	J44.1	COPD (acute) Exacerbation	☐	J84.09	Bronchiolitis Obliterans
☐	J44.0	COPD acute lower respiratory infection	☐	Z99.11	Dependence on respirator (ventilator) status
☐	J44.9	COPD, unspecified	☐	135	Sarcoidosis
☐	J4.2	Unspecified Chronic Bronchitis	☐	G47.33	Obstructive sleep apnea (adult) (pediatric)
☐	J43.9	Emphysema, unspecified	☐	T86.819	Unspecified complication of lung transplant
☐	J84.10	Pulmonary fibrosis, unspecified	☐	Z94.2	Lung transplant status
☐	J47.0	Bronchiectasis with acute lower resp infection	☐	J84.112	Idiopathic pulmonary fibrosis
☐	J47.1	Bronchiectasis with (acute) exacerbation	☐	J84.115	Interstitial lung disease
☐	J47.9	Bronchiectasis, uncomplicated	☐	R53.82	Chronic fatigue, unspecified
☐	J39.9	Disease of upper respiratory tract	☐	I27.0	Pulmonary Hypertension
☐	E84	Cystic Fibrosis	☐	I27.2	Other secondary pulmonary hypertension
☐	E88.01	Alpha-1 Antitrypsin	☐		Other:

X	Pulmonary Therapy

Cardiopulmonary Physical Therapy will be 2-3 times per week for 12 weeks unless otherwise prescribed. During this program the patient will be educated and instructed in the following ways: Respiratory muscle training, Strength training, Upper and lower body conditioning, and Aerobic exercises. In addition the following baseline procedures will be performed for patient evaluation/ progress unless otherwise noted: The Six Minute Walking Test, Simple Spirometer Please attach any recent pulmonary function test results with the referral form.

Comments/Suggestions/Contraindications: _____

_____

_____

_____ _____
Physician Signature **Date**